## Optional Medicaid Benefits Offered in Other States Compared to New Mexico

| Optional Benefit | States Covering Benefit | New Mexico Coverage |
|---|---|---|
| Prescription drugs | 50 | Yes |
| Medical care or remedial care furnished by other licensed practitioners: | | |
| • *Nurse practitioner services* | 49 | Yes |
| • *Chiropractor services* | 28 | No |
| • *Optometry services* | 50 | Yes |
| • *Psychologist services* | 34 | Yes |
| Rehabilitation (mental health and substance abuse) | 49 | Yes |
| Clinic services in an ambulatory surgical center | 48 | Yes |
| Dental services | 45 | Yes |
| Dentures | 34 | Yes |
| Prosthetic devices | 49 | Yes |
| Eyeglasses | 43 | Yes |
| Durable medical equipment | 50 | Yes |
| Hearing aids | 34 | Yes |
| ICF/MR | 50 | Yes |
| IMD for 65 and older | 49 | Yes |
| Inpatient psychiatric hospital services for individuals under age 21 | 50 | Yes |
| Home- and community-based waiver services | 50 | Yes |
| Targeted case management | 49 | Yes |
| Personal care services | 30 | Yes |
| Hospice services | 47 | Yes |
| Services furnished under a PACE program | 29 | Yes |

## States Limiting Benefits in FY08-FY10

| State | Benefits Reduced or Eliminated | Population Affected |
|---|---|---|
| California | Eliminating acupuncture, dental (with exceptions), audiology and speech services, optometry and optician services, podiatry, psychology services, chiropractic services, and incontinence creams and washes. Applies to both managed care and fee-for-service. | Non-institutionalized adults |
| Colorado | Requiring all outpatient clinics to obtain prior authorization for non-emergent CT, non-emergent MRI, and all PET scans. | All |
| Connecticut | Discontinuing coverage for most over-the-counter drugs | All |
| Hawaii | Dental benefits reduced to emergency only | All adults |
| Louisiana | Imposed a 5 prescription limit (with physician override). | Non-institutionalized adults |
| Maine | Adding functional eligibility limits on targeted case management and private non-medical institutional services. | Adults |
| Massachusetts | Discontinued coverage for non-emergency transportation in the Family Assistance, Basic and Essential waiver programs. | Expansion adults |
| Michigan | Eliminated dental, hearing aids, chiropractic care, podiatry, and eyeglasses and associated vision | All adults |

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| | services. | |
| Minnesota | Restricted coverage of circumcisions to only medically necessary indications. Applying limits on dental coverage, such as comprehensive exams once in five years, periodic exams once per year. | All; all adults |
| Nebraska | Dental benefits limited to $1,000 per year; occupational therapy, physical therapy, speech therapy limited to 60 visits per year; hearing aids limited to 1 every 4 years; eyeglasses limited to 1 every 24 months. | All adults |
| Nevada | Eliminated coverage for non-medical vision services. | All adults |
| New Hampshire | Adding prior authorization requirements for occupational therapy, non-emergent ambulance services, and methadone clinics. | All |
| New Jersey | Eliminating coverage of specific cough, cold and cosmetic drugs. | All |
| North Carolina | Applying utilization controls to personal care services. | Aged and disabled |
| Oklahoma | Applied prior authorization for dental coverage for (1) a second set of panoramic films taken within 3 years of the first set, and (2) a second provider to correct poorly rendered restorative procedures by original provider of services. Restricted coverage for the application of ceramic based and cast metal crowns for natural teeth only. | Children |
| Oregon | Reducing vision and dental benefits. | Non-pregnant adults |
| Rhode Island | Reconfigured Community Intensive Treatment services to add utilization controls and to include under managed care contracts. Limiting ER visits to 12 per year. | Children; adults |
| Tennessee | Limited scope of benefits for home health and private duty nursing | Adults |
| Utah | Eliminated audiology and hearing services, physical, occupational and speech therapies, eyeglasses, and chiropractic services. Eliminated coverage of physician services rendered during and inpatient stay in the Primary Care Network (PCN) waiver program. Coverage for all dental benefits eliminated. | Non-pregnant adults; expansion adults |
| Virginia | Implemented prior authorization for mental health services. Applying prior authorization to additional mental health services. | All |
| Washington | DME benefit reduced, including elimination of coverage for bath support equipment, limits on oral enteral nutrition, and new quantity limits on certain medical supplies including incontinence and diabetic supplies and on non-sterile gloves. | All adults |
| West Virginia | Statewide rollout of DRA Benchmark Plan for healthy adults and children that restricts benefits for persons that do not sign or fail to comply with a Member Medicaid agreement. Benefits restricted or excluded include: diabetes care, mental health care, podiatry, and transportation services. Also includes a 4 script per month limit. | Children and parents |
| Wyoming | Applying utilization restrictions to psychiatric residential treatment facilities. Reducing coverage | Aged and disabled; all adults |

| | | |
|---|---|---|
| | on ultrasounds and other radiology. Reducing coverage for eyeglasses (less frequent replacement). | |

## Other Cost-Containment Being Considered by States

*Dental*

- Adjusting pricing and coverage of dental.
- Eliminating dental for pregnant women.

*Pharmacy*

- Modifying the pharmacy reimbursement system to better reflect the pharmacy's true acquisition costs for drugs and the cost of dispensing the drugs, by basing pharmacy reimbursement for acquiring drugs on actual invoices paid by pharmacies.
- Implementing prescription/script limits.
- Including new drug classes into the PDL.
- Utilization management of triptans, otics, fibromyalgia, and antipsychotics.
- Limits on duration of use for proton pump inhibitors (PPIs), requiring prior authorization for ongoing use beyond 90 days.
- Requiring authorization for Advair and Symbicort (inhaled long-acting beta agonist/corticosteroid combination drugs) to verify the client has had a previous trial of an inhaled corticosteroid medication.
- Automatically authorizing lamotrigine (Lamictal) for FDA-approved indications using Expedited Authorization (EA) codes. Prior authorization will be required for all other uses.
- Requiring prior authorization for prescriptions of Seroquel/Seroquel XR dosed daily at 50mg or less; but automatically approving the use of higher doses of Seroquel/Seroquel XR associated with FDA-approved indications.
- Reviewing Medicaid clients who are receiving high doses of opioid narcotics to verify the medical need for these exceptional doses. The screening will only apply to clients with chronic non-cancer pain. For these clients authorization will be required for all opioid narcotic prescriptions.
- Implementing new pharmacy purchasing strategies, including a multi-agency emphasis on putting generics first.
- Changing the payment rate on higher-cost drugs to Average Wholesale Price minus 16%.
- Eliminating OTC medications as a covered benefit.

*Quality Assurance & Program Integrity*

- Reviewing new applications of durable medical equipment providers prior to enrollment to ensure that they have a legitimate office and office staff.
- More rigorously reviewing any provider enrollment application in which the applicant has previously been sanctioned or suspended.
- Reviewing the list of sanctioned individuals to ensure they are not working in any capacity for an entity that receives payments from Medicaid or Medicare.
- Medical necessity inpatient review.
- Eliminating split billing.

- Improving payment accuracy/1 day stay.

*Provider Payment & Benefit Changes*

- Reducing ambulatory surgical reimbursement rates.
- Reducing reimbursement rates for psychologists.
- Modifying Part B ambulance reimbursement.
- Equalizing reimbursement for c-sections and vaginal deliveries.
- Eliminating reimbursement for newborn circumcision.
- Modifying hospital payments for patient transfers.
- Limiting emergency room visits to 3 paid visits per year (non-pregnant adults)
- Eliminating modifier 57 code (separate payment for E&M and procedure codes).
- Eliminating outpatient adult therapies (OT, PT, speech).
- Modifying EPSDT periodicity schedule.
- Provider rate reductions.
- Eliminating state payment of Medicare managed care premiums for dual-eligible seniors in Part C.

*Durable Medical Equipment/Medical Supplies*

- Pricing adjustments for oxygen and capped rental.
- Reducing oxygen payment rates for adults.
- Pricing adjustments for children's nebulizers and eliminating adult nebulizers.
- Restricting number of blood glucose test strips without prior authorization to 100 strips.
- Eliminating other adult products (negative pressure wound therapy pumps, blood glucose monitors, osteogenic stimulators, portable oxygen contents, form-fitting conductive garments, etc.).

*Co-Pays*

- Increasing member co-pays not to exceed federal maximum. For example:
  - Increasing inpatient hospital from $3 to $10 per day with a cap of $90
  - Increasing adult behavioral health from $0 to $3 per visit
  - Increasing home health from $1 to $3 per visit
  - Increasing DME from $0 to $3 per visit
  - Increasing pharmacy from $1 to $2 for prescriptions having a Medicaid allowable of $29.99 or less; and from $2 to $3 for prescriptions having a Medicaid allowable of $30 or more
  - Decreasing preferred generic prescriptions to a $0 co-pay